TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Spine and Joint Hospital

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-17-0384-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "However, our position is that the Hospital provided the medically necessary procedures to the patient to treat her work related injury, and is entitled to reimbursement. Furthermore, as shown on the attached business record, the Hospital reasonably believed that authorization was not required for the procedure."

Amount in Dispute: $9,705.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to Rule 134.600(p)(2) which states, "Non-emergency health care requiring preauthorization includes outpatient surgical or ambulatory surgical services. The Office researched the claim and documentation submitted with the Medical Fee Dispute request to find we are unable to substantiate that preauthorization had been requested by the health care provider to our Utilization Review Agent."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2015	Outpatient Hospital Services	$9,705.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.600 defines the services that require prior authorization.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 197 – Precertification/authorization/notification absent
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered on December 17, 2015 for $9,705.00.

   The insurance carrier denied disputed services with claim adjustment reason code 197 – "Precertification/authorization/notification absent."

   28 Texas Administrative Code §134.600 (p)(2) requires that

   Non-emergency health care requiring preauthorization includes:

   (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

Review of the submitted medical claim finds:

- Claim submitted with "type of bill" in box 4 of UB-04 as 131 or "Outpatient."

The Division reviewed the submitted "patient account detail" but insufficient evidence was found to support an authorization was obtained. Therefore, the Division finds the carrier's denial is supported.

2. Based on the applicable Division rules no separate payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		November 3 , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.